STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6504
603-271-4741 1-800-852-3345 Ext. 4741
Fax: 603-271-4506 TDD Access: 1-800-735-2964

NEW HAMPSHIRE STATE LOAN REPAYMENT PROGRAM APPLICATION

Please type or print:

Name: _____
Last First Middle
Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

U.S. Citizen or U.S. National? ☐ YES ☐ NO DOB: _____

Please check your discipline and provide specialty:

Discipline: ☐ MD ☐ PA ☐ CNM ☐ PNS ☐ MHC ☐ LPC
☐ DO ☐ DH ☐ CP ☐ CNP ☐ CSW ☐ MFT
☐ DDS ☐ DMD

Specialty: _____

Hours work per week: _____
Hours per week administrative duties: _____
How many days do you work per week? _____

Are you Board Certified? ☐ YES ☐ NO If No, When do you plan to receive? _____

Name of School(s), date(s) and degree(s) awarded:

_____

_____

_____

How long employed at current facility? Years: ____ Months: ____
Date Employment Began or Will Begin: _____ Salary/Wage: _____

Employer Name: _____
Practice Name: _____

Primary Practice Site:
Town: _____ Days/week: _____ Hours/week: _____
Practice Address: _____
Town: _____ State: _____ Zip: _____ County: _____
Work Phone: _____ Fax #: _____

Secondary Practice Sites:
1. Town: _____ Days/week: _____ Hours/week: _____

2. Town: _____ Days/week: _____ Hours/week: _____

Is there a sliding fee scale, including free care? ☐ YES ☐ NO
Posted in waiting Room? ☐ YES ☐ NO

Is there any limit on the number of patients seen with Medicare/Medicaid? ☐ YES ☐ NO
If Yes, Explain: _____

Is there any limit on the number of patients seen that are uninsured? ☐ YES ☐ NO
If Yes, Explain: _____

Do you work 40 hours per week, no less than 4 days per week in a patient care practice, of which a minimum of 32 hours per week must be spent in direct patient care (for physicians the practice will include ambulatory care, as well as hospital care appropriate to meet the needs of patients and to assure continuity of care)? ☐ YES ☐ NO How Many Hours? _____ Administrative Hours? _____
If no, please explain: _____

Do you work 20-32 hrs, in a direct patient care practice, of which no more than 4 hours minimum are spent on practice-related administrative activities. ☐ YES ☐ NO How Many Hours? _____
Administrative Hours? _____ If No please explain: _____
_____

Do you or your employer provide prenatal and delivery services? ☐ YES ☐ NO

Do you have any outstanding contractual obligations for health services to the:

Active Military: ☐ YES ☐ NO National Guard: ☐ YES ☐ NO
National Health Service Corps Loan Repayment Program (NHSC LRP): ☐ YES ☐ NO
NHSC Scholarship Program: ☐ YES ☐ NO
Nurse Education Loan Repayment Program (NELRP): ☐ YES ☐ NO
Nursing Scholarship Program: ☐ YES ☐ NO
State or Other Entity: ☐ YES ☐ NO

If yes, when will the service obligation be completely satisfied? _____
Contact Information: _____

Do you have a Perkins Loan that is outstanding? Yes No

If you have a Perkins Loan how much balance still remaining? _____

Have you applied or received a cancellation of your Perkins Loan through your educational institute that made the loan? Yes No If received cancellation, how much? _____

Note: If you have a Perkins Loan you should immediately contact your institution that made the loan, schools may cancel up to 100% of the loan if the borrower has served full time as a/an: teacher, nurse, medical technician, qualified professional provider of early intervention services, staff member in the educational part of a pre-school carried out by the Head Start Act, law enforcement officer, active military services, or in the Peace Corps.

If you answered yes to any of these questions below, attach an explanation to the application.

Do you have a judgment lien against your property for a debt to the United States? ☐ YES ☐ NO

Do you have any federal debt written off as not collectible or any federal service or payment obligation waived? ☐ YES ☐ NO

Has your medical/certification license ever been suspended or revoked? ☐ YES ☐ NO

Are any professional disciplinary actions pending? ☐ YES ☐ NO

Have you ever been convicted or pled guilty to a felony as so defined under either Federal or State laws? ☐ YES ☐ NO

LOAN EXPENSES FOR MEDICAL PROFESSIONAL EDUCATION:

Lender Name/Address/Telephone #	Account #	Original Amt of Loan	Current Balance Due

*Attach other required documents as outlined on the next page.

CERTIFICATION: (Notary Required)

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I understand that the information I have provided is subject to verification and that willfully providing false information may result in disqualification from participation in this program.

Signature: _____ Date: _____

Witness: _____ Date: _____

Notary Public or Justice of the Peace

SEAL

New Hampshire State Loan Repayment Program

Required Supporting Documents for State Loan Repayment Contract Applications

1. Attach a personal statement defining your commitment to serving the underserved populations in the community where you practice. How you along with the practice site will meet the healthcare needs of the community and/or region that you serve. Your practice plans following fulfillment of the loan repayment commitment. Any other information that would be helpful for the RHPC Section in assessing your qualifications to receive funds under this program.

2. Provide an updated resume. (Must have current employer listed)

3. Provide a copy of your NH Board Certified License/Certification to practice in New Hampshire (must show expiration date).

5. Please provide a copy of proof of citizenship or naturalization: (birth certificate, baptismal Certificate, Hospital birth records, US Passport, Alien Registration Card, Naturalization Certificate, any form of documentation defined by Immigration & Naturalization Service (work eligibility), Native American Tribal Documents, DD Form 214).

6. Attach copy of the sliding fee schedule from the healthcare facility (on letterhead) that you will be employed at.
   (Your HR or Accounting Office may help you with this)

7. Attach evidence of your undergraduate or graduate medical or nursing educational loan balance(s).

8. Attach completed Alternate W-9 Form. (Applicant's Information)

9. Attach Completed Employer Information Sheet and all required attachments.

Important: It will be the responsibility of the applicant and/or the facility/community to seek out non-federal matching funds before other funding sources are considered.

Please return completed application to:

David Roberts
Primary Care Workforce Coordinator
Rural Health & Primary Care Section
NH DHHS
29 Hazen Drive, Concord, NH 03301-6504

If you have any questions, please call, 603-271-2276, Fax 271-4506 or E-Mail: droberts@dhhs.state.nh.us

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New Hampshire State Loan Repayment Program (SLRP)
(Employer Questionnaire)

Please print or type and respond to all questions.

Applicant Information

Name of Loan Repayment Applicant: _____

Profession/Specialty: _____

1) Please check one. This applicant is requesting a: ☐ 3 yr contract (F/T) ☐ 2 yr contract (P/T)
How many hours per week in direct care will this applicant be working during the period of the contract? _____

2) Does this applicant have a current and unrestricted License/Certification to practice in their field in New Hampshire? ☐ YES ☐ NO If no, please explain:

3) Does the applicant have a current contract/employment agreement with your organization?
☐ YES ☐ NO
If yes, start date of Applicant: _____ Expiration Date: _____

4) Do you anticipate renewing the contract/employment agreement when it expires? ☐ YES ☐ NO
If no, please explain:

5) Is this applicant's employment contingent on obtaining a state loan repayment? ☐ YES ☐ NO
If yes, please explain:

6) Does the applicant speak a language other than English that is significant to the practice area?
☐ YES ☐ NO Language: _____

Employer Information

Name of Employer Organization: _____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____ E-Mail: _____

Street Address _____

City: _____ State: _____ Zip: _____ County: _____

1) Type of Practice: (please check one)

- ☐ Fed. Qualified Health Center (FQHC)
- ☐ DPHS Funded Clinical Health Center
- ☐ Rural Health Clinic
- ☐ Critical Access Hospital
- ☐ Rural Referral Center
- ☐ Dental Clinic
- ☐ Public, Not For Profit
- ☐ Private, For Profit
- ☐ Other_____

2) Does your healthcare facility have a sliding fee schedule in place, including free care? ☐ Yes ☐ No
Is it posted in the waiting room? ☐ Yes ☐ No

3) Do you accept all patients regardless of method of payment, including Medicaid, Medicare assignment and ability to pay? ☐ Yes ☐ No

4) Describe your payor mix in the last 6 months and describe your bad debt/charity care as % of revenue for the last 6 months.

5) Is this state loan repayment application for: ☐ Recruitment ☐ Retention?
If for recruitment purposes how long was this position vacant? Yrs.___ mos.___
If for retention how long has employee been employed? Yrs.____ mos.____

6) Priority is given to applications that include a 50% facility or community non-federal match. If this applicant is awarded state loan repayment, has your organization and/or community budgeted funds to match 50% of the award each year for the contract? ☐ Yes ☐ No
If full matching funds are not available, a letter describing any extenuating circumstances or hardship must be attached in order for this application to be considered for funding.

7) If unable to provide 50% of the matching funds, what non-federal matching dollar amount is your organization or community able to provide towards the applicant's state loan repayment? $_____

Print Contact Name: _____
Facility's Authorized Representative

Signature: _____
Facility's Authorized Representative

Title: _____ Date: _____

If you have any questions, please call, 603-271-2276, Fax 271-4506 or E-Mail: droberts@dhhs.state.nh.us
To learn more about the State Loan Repayment Program you may go to our web site at:
http://www.dhhs.nh.gov/DHHS/RHPC/default.htm

Mailing Address: David Roberts
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Rural Health & Primary Care Section
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